RICHARD A. URBANEK, JR., DDS, MS, PA
BOARD CERTIFIED
ORAL & MAXILLOFACIAL SURGEON

NEW PATIENT REGISTRATION FORM

______________________________ _____/_____/_____ _____
PATIENT'S NAME (LAST, FIRST MIDDLE) DATE OF BIRTH AGE

______________________________ (______)__________________
ADDRESS (STREET) HOME PHONE

______________________________ (______)__________________
ADDRESS (CITY, STATE, ZIP) WORK PHONE

___ M ___ F ________ - _____ - ________ (______)__________________
SOCIAL SECURITY NUMBER CELL PHONE

______________________ ______________________ ______________________
EMPLOYER OCCUPATION HOW LONG HELD

______________________________ ______________________________
FAMILY PHYSICIAN PHONE FAMILY DENTIST PHONE

IF INSURANCE IS UNDER YOUR SPOUSE, THEN PROVIDE THE FOLLOWING:

______________________________ ______/______/______ _____
SPOUSE'S NAME (LAST, FIRST MIDDLE) DATE OF BIRTH AGE

________ - _____ - ________ (______)__________________
SOCIAL SECURITY NUMBER WORK PHONE

______________________ (______)__________________
EMPLOYER CELL PHONE

PLEASE COMPLETE BELOW IF PATIENT IS A MINOR:

______________________________ ______________________________
FATHER'S NAME (LAST, FIRST MIDDLE) MOTHER'S NAME (LAST, FIRST MIDDLE)

______________________________ ______________________________
ADDRESS (STREET) ADDRESS (STREET)

______________________________ ______________________________
ADDRESS (CITY, STATE, ZIP) ADDRESS (CITY, STATE, ZIP)

(______)______________ _______ - _____ - _______ (______)______________ _______ - _____ - _______
HOME PHONE SOCIAL SECURITY HOME PHONE SOCIAL SECURITY

(______)__________________ (______)__________________
CELL PHONE CELL PHONE

(______)__________________ _____/_____/_____ (______)__________________ _____/_____/_____
WORK PHONE DATE OF BIRTH WORK PHONE DATE OF BIRTH

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT. I AM AWARE MEDICARE DOES NOT COVER DENTAL PROCEDURES. I AUTHORIZE RELEASE OF INFORMATION RELATING TO TREATMENT.

PATIENT SIGNATURE:______________________________ DATE: ________________
(PARENT SIGNATURE IF PATIENT IS A MINOR)

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO DR RICHARD A. URBANEK, JR. FOR TREATMENT RENDERED.

PATIENT SIGNATURE:______________________________ DATE: ________________
(PARENT SIGNATURE IF PATIENT IS A MINOR)